Compassion Fatigue:

A History of the Concept[1]

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Traumatology is the study of trauma and the language used to describe select phenomena. Terminology used to describe the aftermath of care giving is varied (Jenkins and Baird 2002; Stamm 1997; Figley 1995) and there has been some professional confusion about how to utilize and distinguish the various terms (Rothschild 2006, 13). Stamm acknowledges this,

> The great controversy about helping-induced trauma is not "Can it happen?" but "What shall we call it?" After reviewing nearly 200 references from PILOTS, Psychlit, Medline, and Social Sciences Index, it is apparent that there is no routinely used term to designate exposure to another's traumatic material by virtue of one's role as a helper. Four terms are most common: Compassion Fatigue; Countertransference; Secondary Traumatic Stress; and Vicarious Traumatization. (1997, 1)

In an attempt to bring some clarity to the development of nomenclature, the following section will provide an abridged history of the phenomena up to the present day. Developments will be traced by the year that they appear in the literature.

In his article "Compassion Fatigue: A Crucible for Transformation", Gentry traces the history of terminology back to Carl G. Jung's 1907 discussion of Countertransference, in *The Psychology of Dementia Praecox*. This concept led to the first published literature examining the effects of therapy upon the therapist (Gentry 2002). "The Freudian classical definition of Countertransference refers to the analyst's unconscious and neurotic reactions to the patient's transference; Countertransference emanates from the repressed and regressive conflicts of the therapist" (Fauth 2006, 17). It is significant to note as I struggle to understand Compassion Fatigue, that Countertransference itself can be a slippery term. In other words, choosing this term to articulate the phenomena may not lead to greater clarity. Fauth explains,

> A number of major definitions exist along with innumerable variations and permutations. The lack of conceptual clarity about the term both results from and reinforces the general theoretical fragmentation in the field, thus inhibiting research on the construct. Clearly we need to come to some general consensus on the term before a Countertransference program can flourish. (2006, 16)

Fauth proposes holding to a moderate definition, defining Countertransference as the therapists' conscious or unconscious reactions (broadly defined as sensory, affective, cognitive, and behavioral) to a client that are based primarily in the therapist's own personal conflicts, biases, or difficulties. These reactions can be triggered by transference, client characteristics, or other aspects of the therapeutic situation (Fauth 2006, 17). Although definitional difficulties exist, contemporary research continues to demonstrate this phenomena suggesting that therapists may experience repercussions that mimic the symptoms of their clients (Pearlman & Saakvitne 1995, 151; Fauth 2006, 17).

Writing in the mid-1970s, psychologist Herbert Freudenberger introduced the term burnout (1974) in his classic article, "Staff Burnout," published in the *Journal of Social Issues*. The concept was first mentioned in relationship to mental health workers in Pines and Maslach's article "Characteristics of Staff Burnout in Mental Health Settings" (1978). By 1982, Maslach describes the phenomena as,

> A syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people work of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems. A pattern of emotional overload and subsequent emotional exhaustion is at the heart of the burnout syndrome. (1982, 3)

By 1988, Pines and Aronson defined burnout as a "state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations (1988, 9). In the 1980s, the burnout syndrome was understood to be a response to chronic emotional strain and may be one result of trauma care, but the terminology implies a pattern of general emotional overload and does not describe repercussions unique to addressing the needs of a single traumatized person.

Charles Figley became interested in combat-related stress reactions after his return from Vietnam in the late 1960s. In 1974, he constructed a bibliography including everything he could find concerning war veterans and combat-related stress reactions (Gilman 1989, 2). In his interview with Gilman, Figley comments,

> I and my colleagues were interested in the tracks of trauma: how does it play itself out in people's lives? The prevailing view was that when the war was over physically, it was over psychologically, and those who took a much longer time to readjust were probably psychologically impaired when they entered the service. But through our research, we clearly refuted that thesis. (Gilman 1989, 3)

In his 1978 article titled "Psychosocial Adjustment Among Vietnam War Veterans: An Overview of the Research," Figley suggested that "family, friends, and professionals are susceptible to developing traumatic stress symptoms from being empathetically engaged with victims of traumatic events" (Cornille & Meyers 1999, 2). Through his work with families of war veterans, Figley became interested in the manner in which family and helpers are impacted by the trauma experienced by the veteran. In a keynote address in 1982, Figley spoke of Secondary Victimization as a repercussion of caring for others in emotional pain (Figley 2006). He writes, "Although I now refer to it as Compassion Fatigue, I first called it a form of burnout, a kind of Secondary Victimization" (Figley 1995, 2). In the following year in "Catastrophes: An Overview of Family Reactions," Figley referred to the phenomena as Secondary Traumatic Stress (STS). By 1985, Rosenheck and Nathan used the term in their article concerning children of Vietnam war veterans, and in the same year, Figley wrote that members of family systems could be traumatized by concern and that this trauma could be subdivided into four separate classifications including,

> 1. Simultaneous Trauma: takes place when all members of the system are directly affected at the same time, such as by a natural disaster; 2. Vicarious Trauma: happens when a single member is affected out of contact with the other members (e.g., in war, coal mine accidents, hostage situations, distant disasters); 3. Intrafamiliar Trauma/or

> Abuse: takes place when a member causes emotional injury to another member; and 4. Chiasmal or Secondary Trauma: strikes when the traumatic stress appears to "infect" the entire system after first appearing in only one member. (Figley 1995, 5)

Rothschild notes that Secondary Trauma as a term was used for many years to describe the effects of traumatic contagion (how trauma symptoms can be caught like a cold, from others within a family system) (2006, 13). With the writing of Stamm's first edition of *Secondary Traumatic Stress* published in 1995, Secondary Trauma would be aligned, for the first time, with Vicarious Traumatization (Stamm 1999, xx).

While Figley was attempting to clarify his findings with adequate language, other sources were developing along similar lines. Perhaps the most significant of these developments occurred in 1980 with the publishing of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). The DSM-III contained a description of Post- Traumatic Stress Disorder (PTSD) described as, "The development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience" (1980, 236).

In 1992, Herman cogently debunked this DSM-III qualification of PTSD writing that, sadly, traumatic experiences are not outside the range of usual human experience; they are, instead, extraordinary events, not because they are rare, but because they overwhelm the ordinary human adaptations to life (1992, 33). Unlike commonplace hard-times, traumatic events involve a threat to life or bodily integrity and encounters with violence and death. They confront human beings with the severity of helplessness and terror, and evoke the responses of catastrophe. The commonalities of psychological trauma include: intense fear, helplessness, loss of control, and threat of annihilation (Herman 1992, 33). Although additional clarity, such as Herman's, was offered in years to come, DSM-III did provide satisfying nomenclature, clearly defined symptoms, and diagnostic parameters to what had been an amorphous reality to therapists for

years. PTSD included concomitant elements to the syndrome, but with the publishing of the DSM-III, it clearly became distinct as a psychiatric disorder. This was a critical turning point in the development of both the concept and the diagnosis; the inclusion of PTSD in the DSM-III brought significant order to the research in traumatology (Figley 1999, 5).

The controversy referring to nomenclature seems to begin after the publishing of the DSM-III. In the 1980s, therapists and researchers begin to utilize terminology just as Figley did, adjusting terms and definitions to fit their specific area of interest. Some of the terms that appeared in the literature included Critical Incident Stress (Mitchell 1983); Vicarious Traumatization (Terr 1985); Secondary Survivor (Remer and Elliot 1988); and Emotional Contagion (Miller, Stiff, and Ellis 1988). In 1990, McCann and Pearlman published their landmark article, "Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims" (McCann and Pearlman 1990). Pearlman and Mac Ian explain the development of the concept,

> Therapists have long treated victims of violence. It is only in recent years, however, that survivors of violent crimes, including childhood sexual abuse, war, genocide, and rape, have come forward in large numbers for psychotherapy. This burgeoning population of clients places new demands on both the expertise and the personal resources of psychotherapists, who may be ill-prepared for this work (Alpert and Paulson 1990; Pope and Feldman-Summers 1992). In an effort to describe the effects trauma work can have on psychotherapists, McCann and Pearlman (1990) coined the term Vicarious Traumatization, which they conceptualized within constructivists self development theory (CSDT: McCann and Pearlman 1990; Pearlman and Saakvitne 1995). (Pearlman and Mac Ian 1995, 558)

Vicarious Traumatization is a "process of change resulting from empathic engagement with trauma survivors" (Pearlman 1999, 52). For Pearlman, the hallmark of Vicarious Traumatization is a disruption in one's sense of identity, worldview, and spirituality; all components that constitute one's frame of reference (Pearlman 1999, 53). This disruption can be extremely painful for the helper and can persist for months, or even years after work with a traumatized

person (McCann and Pearlman 1990, 133). Saakvitne and Pearlman offer further clarity in their seminal work, *Transforming the Pain*. They write,

> Vicarious Traumatization is our strong reactions of grief, rage, and outrage, which grow as we repeatedly hear about and see people's pain and loss and are forced to recognize human potential for cruelty and indifference, and it is our numbing, our protective shell, and our wish not to know, which follow those reactions. (Saakvitne and Pearlman 1996, 41)

As Saakvitne and Pearlman were polishing their own constructs for the phenomena, Carla Joinson published "Coping with Compassion Fatigue" (1992) for the nursing community. In the article, Joinson attributes the term Compassion Fatigue to crisis-counselor Doris Chase (Joinson 1992, 116). This is the first time that this nomenclature is used in the literature to describe the therapist's experience of caring for those in crisis (Figley 1995, 15). In her article, Joinson recognizes four reasons for acknowledging the transformative power of Compassion Fatigue: Compassion Fatigue is emotionally devastating; caregivers' personalities lead them toward it; the outside sources that cause it are unavoidable; and finally, Compassion Fatigue is almost impossible to recognize without a heightened awareness of it (Joinson 1992, 116).

In addition, Joinson writes of three core issues in Compassion Fatigue. First, she points to the connection between helping and the person of the caregiver, stating that, "the essential product they (counselors) deliver is themselves" (1992, 117-118). Second, human need is infinite; and third, caregivers fill multiple roles that can be psychologically conflicting (1992, 117-118). In the same year, Figley referred to the phenomena as 'Compassion Stress' (Figley 1992) and Herman in *Trauma and Recovery* called it 'Traumatic Countertransference' (Herman 1997, 140). Herman writes,

> Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient. This phenomenon is known as "Traumatic Countertransference" or "Vicarious Traumatization". (Herman 1997, 140)

In 1993, in an effort to standardize nomenclature, Stamm and Figley discussed the viability of utilizing Compassion Fatigue instead of STS. There seemed to be a sense from both Stamm and Figley that STS was being perceived as defamation (Stamm 1999, xx; Figley 1995, 15). Stamm calls STS a harsh label and states that it is not a name one wants associated with their ability to care (Stamm 1999, xx). Figley found that nurses expressed concern with the perceived derogatory nature of diagnostic language like STS (Figley 1995, 15). Stamm continues writing of her own struggle with the term,

> Although I had helped with the development of the Compassion Fatigue Self-test (Figley and Stamm, 1996), in 1995 I dropped this term because of its use by the media in regard to public apathy regarding homeless people. In 1999, the media use the term less and I find that I am using it more. There are two reasons for that. First, it is a term that many frontline workers use to think about themselves. Second, there is something to the labeling aspect of it. Even with this, I am not entirely satisfied with any of the terms we use. (Stamm 1999, xx-xxi)

By 1998 Figley revised his definition to read, "Compassion Fatigue is defined as a state of exhaustion and dysfunction – biologically, psychologically, and socially – as a result of prolonged exposure to Compassion Stress and all that it evokes. It is a form of burnout" (1998, 23).

Secondary Traumatic Stress (STS) is a term utilized both for its content and its accuracy, but the issues mentioned make it significantly less palatable. Although the term is not yet defined in the Diagnostic and Statistical Manual of Mental Disorders, according to Figley, STS is, "The natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley 1999, 10). Gilbert suggests that STS is the result of the supporter's efforts to understand and emotionally connect with the primary survivor. In her work on Traumatic Stress and spouses, she further sub-divides the phenomena into Distal: events in

the imagination; and Proximal: living with a primary survivor of trauma (1998, 49). Compassion Stress is a term defined by Figley in almost exactly the same manner as STS, which does add to the lack of precision regarding nomenclature. Compassion Stress is, "The natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized person (Figley 1995, xiv).

Secondary Traumatic Stress Disorder (STSD) is similar, but is a term used to describe experiences so traumatically stressful, requiring such a dramatic demand for personal change that psychosocial resources are sufficiently challenged to result in pathology (Stamm 1999, xxxvii). In contrast to burnout, which emerges gradually, STSD can emerge suddenly without much warning. Furthermore, unlike burnout, with STSD there is a sense of helplessness, confusion, and isolation from support with symptoms often disconnected from actual causes (Figley 1998, 17). STSD is described as a syndrome of symptoms nearly identical to PTSD, except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress (Figley 1995, 8).

In 1994, the DSM-IV contained a new description of post traumatic stress disorder. This new definition states that PTSD is,

> The development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. (DSM-IV 1994, 424)

It is significant to note that this expanded definition included not only the primary experience of trauma, but 'learning about unexpected or violent death.' The other significant change in the DSM-IV is the addition of Acute Stress Disorder. The first part of the diagnostic criteria states,

> A. The person has been exposed to a traumatic event in which both of the following are present:
>
> > a. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
> >
> > b. The person's response involved intense fear, helplessness, or horror. (DSM-IV 1994, 431)

From the year 2000 to the present, several new terms have surfaced in the literature. Stebnicki uses 'Empathy Fatigue' (Stebnicki 2000) to distance the phenomena from burnout and to align his concept with Figley's Compassion Fatigue. Stebnicki writes,

> *Empathy fatigue* transcends the experience of professional burnout. The experience of burnout emerges gradually within the individual and results in cumulative emotional and physical exhaustion. Compassion Fatigue (Figley 1995) or *empathy fatigue*, as described here, can emerge suddenly with little warning as an unhealthy form of Countertransference or Secondary Traumatic Stress. (2000, 23)

The reader will note that Stebnicki is utilizing several terms interchangeably; Empathy Fatigue, Compassion Fatigue, Countertransference, and STS; and all seem to be subsumed under the same definition. Stebnicki here distinguishes his understanding of Compassion Fatigue/Empathy Fatigue from burnout; however, it may be premature to dismiss burnout completely. Research efforts regarding the syndrome and its relationship to Compassion Fatigue, STS, and Vicarious Traumatization are ongoing (Figley 2002; Gentry, et al, 2002; Jenkins and Baird 2002; Nelson-Gardell and Harris 2003; Salston and Figley 2003; and Stamm 2002). Schauben and Frazier (1995) found that trauma therapists showed positive results for Vicarious Traumatization, while not showing similar results on a burnout scale (Cunningham 2003, 2).

Furthermore, Figley has outlined quite clearly that although there are common elements, Secondary Trauma is not the same as burnout (1999, 15-17), and each phenomena should be treated as having a unique effect upon a professional's wellbeing (Jenkins and Baird 2002; Sabin-Farrell & Turpin 2003; Salston and Figley 2003). As recently as 2006, Adams, Boscarino, and Figley note in their work with New York City social workers that there is, however, a relationship between Secondary Trauma and job burnout, in that both are marked by the emotionally fatiguing nature of working with trauma survivors (Adams et al, 2006, 5). Interestingly, the instrument they utilized for this research was designed to measure what they referred to as the *two components* of Compassion Fatigue: Secondary Trauma and job burnout. In his work with clients, Gentry has found that addressing the individual's primary trauma is often necessary before attempting to work through his/her secondary trauma (Gentry 2002). Instead of forcing an unnatural divide between Compassion Fatigue and burnout, Gentry chooses to recognize a synergistic relationship existing between primary traumatic stress, STS, and burnout (Gentry 2002). In their attempt to clarify the conceptualizations of helper stress, Thomas and Wilson propose 'Traumatoid States' as an appropriate and inclusive term to characterize the occupationally-related stress response syndromes (OSRS), including Compassion Fatigue, STS, and Vicarious Traumatization (Thomas and Wilson 2004, 81). Although the suggestion may be accurate, it may be perceived as yet another offensive, unacceptable judgement on those who work in the field of trauma.

Comparative Summary

The survey of nomenclature traced the phenomena beginning with the concepts of Countertransference and burnout. Do these qualify as adequate nomenclature to describe the helper's experience of trauma? The problematic answer is, of course, both yes and no. The

problem with using Countertransference as the sole moniker is that it also occurs in situations where trauma is not a concern. It is not specific to the traumatic encounter. Stamm writes, "I believe Countertransference applies more to how our patients affect our work with them, and Compassion Fatigue/Secondary Traumatic Stress/Vicarious Traumatization is about how our patients affect our lives, our relationships with ourselves, and our social networks, as well as our work" (1997, 1). In like manner, burnout is not identical to Compassion Fatigue, but is a component part. Cunningham states that "neither Countertransference nor burnout alone adequately accounts for the impact on the clinician of the graphic material presented by the traumatized client" (2003, 2). Using the term 'Secondary Traumatic Stress Disorder' forces the issue of diagnosable pathology which advances the discussion beyond the scope of this work. Stamm suggests considering traumatic stress as not simply a diagnosable pathology, but as a larger part of the concept of stress, which can include Secondary Traumatic Stress but is not limited to, the mental disorders of Acute Stress Disorder or PTSD (Stamm 1999, xxxvii-xxxviii).

Post Traumatic Stress Disorder does not adequately account for the impact of caring upon the helper. Lerner observes that traumatic stress is not PTSD. He would suggest that Traumatic Stress be understood as a normal response to an abnormal event (Lerner 2005, 18) and not a disordered response to a normal event. PTSD is a psychiatric disorder that cannot be diagnosed until symptoms persist for one month. This does not make room for the immediate repercussions of traumatic stress upon the helper, nor is it reasonable to suggest that all trauma leads to a disorder. In fact, Van Der Kolk and McFarlane believe that most people exposed to horrific and dreadful experiences survive without developing a psychiatric disorder (Van Der Kolk and McFarlane 1996, 3).

Vicarious Trauma (McCann and Pearlman 1990); STS (Figley 1987; Stamm 1995); and Compassion Fatigue (Joinson 1992; Figley 1995) "have all become cornerstones in the vernacular of describing the deleterious effects that helpers suffer when working with trauma survivors" (Gentry 2002).

In summary, Compassion Fatigue is a more user-friendly term that is connected to STS, burnout, and PTSD, but that also has something unique to bring to the understanding of the specific trauma encounter. Compassion Fatigue is the most versatile term and is able to be used synonymously for Compassion Stress (Figley 1995, xiv; Stamm 1999, 11) and Secondary Traumatic Stress Disorder (Figley 1995, xv; Figley 2005, 2; Stamm 1999, 11). Figley writes, "Secondary Traumatic Stress phenomenon has been called different names over the years. Indeed we will suggest that Compassion Stress and Compassion Fatigue are appropriate substitutes" (Stamm 1999, 11; Figley 1995, 15). In addition, Boscarino, et al. for the purpose of their research, qualify the terminology further adding that Compassion Fatigue can be understood as "reduced capacity or interest in being empathic or bearing the suffering of clients" (2004, 2). Although Rothschild's definition lacks precision, it is rather palatable, "Compassion Fatigue is a general term applied to anyone who suffers as a result of serving in a helping capacity" (2006, 14).

It seems wise to acknowledge that there are indeed a number of epistemological concerns regarding whether Compassion Fatigue/Secondary Traumatic Stress/Vicarious Traumatization is a disorder (Stamm 1999, xxiv). Stamm has argued for its inclusion under the rubric of PTSD, but further recognizes that "reactions following indirect exposure because of another's trauma do not have to be a disorder" (1999, xxiv). Furthermore, in emphasizing that Compassion Fatigue is natural behaviors and emotions, Figley makes it clear that it is not pathological (Simpson 2005,

17). Although nomenclature is yet unsatisfying, I will conclude this historical survey with my own definition, drawing from the research provided above,

> Compassion Fatigue is the natural behaviors and emotions resulting from Secondary Traumatic Stress, which can be defined as: the stress associated with helping or wanting to help a traumatized or suffering person, resulting in a reduced capacity or interest in being empathic. Although it may lead to burnout, it can emerge suddenly and without warning.

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